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Department of Health and Welfare

Single Audit Management Letter

Issued: June 25, 2002
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Legislative Audits' Management Letter

Department of Health and Welfare

PURPOSE AND SCOPE – In planning and performing our audit of the statewide Single Audit report of the State of Idaho for the fiscal year ended June 30, 2001, we completed certain financial audit procedures on the Department of Health and Welfare's financial activities that occurred during the fiscal year. The scope of work was limited to the Department's federal major program as determined for the statewide Single Audit. Therefore, we considered the internal control structure to determine appropriate procedures and required tests, along with procedures performed at other State agencies, that would allow us to express our opinion on the statewide Single Audit report and not to provide assurance on the Department's internal control. (Because this is not a full report, but an interim management letter on the agency, there are no other attachments to this letter.)

CONCLUSION – This letter contains seven findings and recommendations. Although we include seven findings and recommendations, we conclude that the financial operations of the Department of Health and Welfare meet accepted standards and that the Department substantially complies with laws, regulations, rules, grants, and contracts for which we tested compliance.

FINDINGS AND RECOMMENDATIONS – The seven findings and recommendations summarized below relate to the federal major program as follows:

Finding #1

Eligibility for the Children's Health Insurance Program was improperly determined in more than 25% of cases tested.

CFDA Title and #:	Children's Health Insurance Program – 93.767
Federal Award #:	05-005ID5028
Program Year:	October 1, 1999 to January 1, 2001
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	E – Eligibility
Questioned Costs:	$3.1 million federal share

Eligibility for the Children's Health Insurance Program (CHIP) is established by the Department under broad federal guidelines. The primary eligibility requirements are described in the Department's Administrative Rules (APA 16.03.01.504) and include the following:

1. Child is under the age of nineteen
2. Child has no health insurance coverage
3. Child is not eligible for other Medicaid programs
4. Family resources are less than $5,000
5. Family income is less than 150% of federal poverty

The Department had 11,114 children enrolled in CHIP as of June 2001. We randomly selected 53 clients who received CHIP benefits during FY 00 and 01 to perform various eligibility tests. These tests included a review of computerized case data and selected documents from the case files kept at the region offices. We then confirmed our

conclusions with central office staff.

We found that 14 of 53 clients tested (26%) were not eligible for CHIP. Seven of these clients were eligible for other Medicaid programs. However, the remaining seven were not eligible for CHIP or any other type of Medicaid assistance. For example:

1. The applicant was an 18-year-old child in a household size of four. The child's earned income of about $1,000 per month was documented but was excluded in error when determining family income limits. As a result, benefits of $2,481 were provided in error.

2. The applicant was an 18-year-old child in a household size of two. The parent's income was greater than 150% of federal poverty which was documented but not properly considered. As such, benefits of $2,530 were provided in error.

3. The applicant was an 18-year-old child who had student health insurance through the University of Idaho. This coverage should have made the applicant ineligible for CHIP. However, benefits for dental and vision services of $351 were paid in error.

4. The applicant family owned a second home but this resource was omitted in the determination of eligibility. The value of this resource would likely have made the family ineligible for $122 in vision benefits.

We believe the error rate could be higher if application data were confirmed to outside sources or other tests were performed. Most errors occurred due to the complex nature of the eligibility requirements, the outdated computerized system used to record and process data, and clerical errors or misunderstandings of the rules by staff.

Eligibility requirements vary significantly among the Medicaid programs, particularly in the amounts and types of income and resources considered. Families with various relationships and multiple children further increase the complexity and chances for error. In addition, the Department's computerized eligibility system (known as "EPICS") lacks the sophistication and capability to assist staff in properly determining eligibility. This system was initially developed in the late 1970's and is no longer an effective tool in processing data and determining eligibility.

Other errors were simply clerical mistakes or overlooked significant data obtained during the application process. All these factors raise the potential for staff to misinterpret the rules, improperly count or omit income and resources, and ultimately determine eligibility in error. The absence of a comprehensive supervisory review process, particularly at the time of approval, was also a factor that allowed these errors to occur and go undetected.

During FY 01, the Department received nearly $12 million in federal

funding for CHIP. Based on the results of our tests, we estimate that $3.1 million was expended for services to ineligible clients. Although half of these costs are allowable to other Medicaid programs, the other half is unallowable to any Medicaid program and could result in a refund to the federal government.

Recommendation #1

We recommend that the Department reduce the errors in determining CHIP eligibility by taking the following steps:

1. Improve or replace the existing "EPICS" automated eligibility system. The system should limit the decisions made by staff and base eligibility on data from client application forms.

2. Establish a supervisory review and approval process for all Medicaid applications to ensure that eligibility is properly determined.

3. Provide additional staff training regarding income, resources, and other criteria for determining eligibility for CHIP.

4. Review all current CHIP clients to confirm that eligibility was properly determined and adjust or cancel those who are ineligible. The federal share of benefits provided to ineligible clients should be resolved with the federal grantor.

Corrective Action Plan

The following serves as a response to each of the auditor's recommendations:

1. Improve or replace the existing EPICS automated system. In November of 2001, the Agency completed a major system modification to EPICS which helps ensure the accuracy of eligibility determinations. At the time of this legislative audit, these cases were completed manually and this was very error prone. This system enhancement correctly calculates income and assets.

   The Automated Medicaid Eligibility Determination (A-Med) is a Department approved enterprise project. This project, which is currently in the design phase, creates a new automated system which will automatically assign Medicaid coverage groups based on an applicant's circumstances. Further, the system will make this determination on a monthly basis, adjusting coverage groups as necessary. This will provide the state with accurate participation data needed to maximize the use of Federal Financial Participation (FFP) rates.

2. & 4. Complete 100% review of applications and open CHIP cases. Since December 1999, our Quality Control unit completed 1,868 Medicaid reviews of applications, renewals, denials and closures. Cases were reviewed on a monthly basis, and the number of cases reviewed was a statistically valid sample, therefore providing an accurate reflection of the quality of these cases. The Agency will continue its focus of completing 2nd

level reviews of our CHIP applications and open cases. We are also instituting a formal supervisory review process of completing these reviews in each of the field offices.

3. Provide training. Numerous training sessions and mini reviews have been completed with workers in the field offices from October 1999 through present. These training sessions and the continued case review focus has helped to improve the accuracy of these Medicaid cases over the last three years.

Finding #2

Temporary assistance to needy families (TANF) emergency assistance funds are used for questionable purposes.

CFDA Title and #:	Temporary Assistance to Needy Families – 93.558
Federal Award No.:	G0001IDTANF
Program Year:	October 1, 1999 to June 30, 2001
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	B – Allowable Cost/Cost Principles
Questioned Costs:	Not Determinable

Federal funds under the Temporary Assistance to Needy Families (TANF) program are available to assist needy families and reduce or eliminate their reliance on government assistance. Federal regulations allow the Department broad latitude in developing and funding programs that meet these objectives.

During FY 01 the Department disbursed more than $36 million in TANF program funds for various direct benefits and services to clients. Our evaluation focused on benefits for "emergency assistance" which were paid to families to address emergency conditions.

Department rules establish the requirements for needy families to receive emergency assistance. In general, the family must have a child under the age of 21 and have an emergency condition that places the child at risk of physical harm or placement outside the home. The benefits provided must meet the needs resulting from an emergency or crisis. The assistance to resolve the emergency cannot cover ongoing expenses or replace funding available from other programs or resources.

Our tests of emergency assistance payments identified questionable uses as follows:

1. An applicant received $415 for a VCR, bicycle equipment, helmets, and a wading pool. Data in the file justified these costs because it was "difficult for the family to stay focused on productive recreational activities." The lack of recreational activities is not an emergency condition, nor does it place the child at risk of physical harm or removal from the home.

2. A family was given $200 in grocery vouchers to entice them to attend counseling. The family had private insurance, but the husband refused to attend counseling because their private insurance co-pay of $25 per visit would require that they sacrifice other needs. Food assistance is available from other programs and

the need for counseling does not meet the definition of an emergency condition.

3. A client received $200 to have a tattoo surgically removed because the tattoo prevented the client from gaining employment. Medical procedures generally are not allowable costs under the emergency assistance rules or under any other programs funded by TANF.

Many of the remaining emergency assistance payments we tested were for rent, utilities, and related housing costs. Although these costs generally are allowable, some payments appeared unrelated to the emergency condition. For example, a family needed funds for travel costs that were denied by Medicaid. Emergency assistance funds were provided to pay their rent for several months so the family could use their resources to pay for the travel.

Travel costs were the family's identified "emergency condition." However, the rent assistance was not directly related to resolving the emergency as required by Department rules. In addition, we believe travel costs in this family's circumstance is a questionable use for emergency assistance because it does not meet the Department's "emergency" definition.

Case workers have received guidance that suggests ways to avoid potentially questionable costs, simply by paying for appropriate types of assistance such as rent and housing costs. This approach makes it difficult to evaluate whether assistance for rent actually resolved the family's emergency condition. The potential exists that some rent payments simply allowed the family to fund other conditions, which were inappropriate uses of emergency assistance funds.

As a result, the possibility exists that TANF benefits under the emergency assistance program were provided for unallowable services. The amount of questioned costs cannot be readily estimated due to the variety of circumstances and conditions that can exist.

Recommendation #2

We recommend that the Department provide additional training to staff on the allowable uses of emergency assistance funds as described in State rules and federal regulations. This should include clarifying existing policies and guidance with examples of allowable emergency conditions that can be funded. Emergency assistance should directly resolve the emergency condition and not indirectly pay for other expenses.

Corrective Action Plan

During this entire audit period, an Executive TANF Steering Committee and cross-division EA work group revised EA policies and procedures. The purposes of these work efforts included: 1) Establishing an EA regional and state-level continuous quality improvement system using retrospective review and utilization management strategies; 2) Developing curriculum including a power point presentation, trainers manual and learners manual, Interpretive Guidelines and a Frequently Asked Questions Document; 3) Training all direct service staff in the Divisions of Welfare, FACS and Medicaid about EA funding, EA

eligibility criteria including the 1994 Child Protection Emergency Response Guide, eligible services and PCA codes, 4) Adopting best practice standards for child welfare intervention, which specified a comprehensive assessment of risk approach to defining emergencies and response, rather than making payments to fix presenting symptoms or issues.

In August of 2000 a training of trainers curriculum was delivered to regional EA trainers and they were provided the above-mentioned training materials.

By October 2000, all seven regions established cross-program EA Utilization review teams. The teams began retrospectively reviewing cases for compliance and quality, providing consultation prospectively on a case-by-case basis, monitoring utilization, issuing quarterly and annual reports, developing corrective action plans including further training, and making case-specific recommendations for corrective supervision.

Since inception of the EA Utilization Review Process, each regional team has submitted an annual report. These reports have been compiled into two aggregated statewide reports, containing regional, training and statewide recommendations.

Many of the regional Utilization Review Teams have conducted follow-up or new worker training.

The Utilization Review Team is also convened for periodic conference calls to discuss issues, concerns and strategies and utilization. One specific training need the Utilization Review Chairs have identified is training and technical assistance on outcome measurement. The purpose of outcome measurement would be to demonstrate that the comprehensive assessment approaches and strategic application of short-term resources really do make a difference in protecting children and promoting self-reliance.

Since inception of the EA Utilization Review process, at least one region has initiated some outcome measurement. Additionally, the Community Resources for Families Program (the DHW sponsored program that uses the largest amount of EA funds) has released several statistical and outcome reports, documenting the effectiveness of a comprehensive assessment approach and the use of short term EA funds to address poverty related needs such as food, utilities, housing, etc. On 4/22/02 FACS consulted the Bureau Chief and TANF Policy Specialist in the Division of Welfare regarding the issues contained in this audit, specific to the latitude states have in adopting title IV-A (pre-TANF) rules for maintaining an EA program.

A conference call with the EA Regional Utilization Review Chairs was previously scheduled for 4/25/02. These audit findings will be added to the agenda and the UR Team will develop further strategies to clarify existing policies and guidance with examples of allowable emergency conditions that can be funded. Additionally, the regions will be asked

to provide a list of training already provided subsequent to the audit period or dates for upcoming training. A School Coordinator conference call will be scheduled prior to May 3, to discuss the same issues noted immediately above. The results of these discussions will be reported to the Division Management Team on May 14, 2002.

We will consider policy implications and seek input regarding the need for policy revision. If policy revisions are needed, the Division Administrator and or/ the TANF Executive Steering Committee will be consulted.

We will convene the Statewide Utilization Review Team during 2002 for their annual meeting (this meeting was delayed due to budget constraints). The purposes of this meeting would be to: 1. Share information about documents and strategies developed by the regional teams; 2. Receive technical assistance for planning outcome evaluation; 3. Make more detailed recommendations regarding budget allocation and program improvements; and 4. Review emerging regional issues that might be addressed statewide. Such issues include contracting out the EA case management functions, appeals, ongoing training needs.

Finding #3

The federal financial reports for child support contain errors.

CFDA Title and #:	Child Support Enforcement – 93.563
Federal Award #:	G0004ID4004
Program Year:	October 1, 1999 to August 22, 2001
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	L – Reporting
Questioned Costs:	Not Determinable

Federal regulation (45 CFR 302.15) requires the Department to submit quarterly reports of amounts collected and distributed. These reports summarize collections by type and source and show the balance remaining for distribution. The Department's source for this information is the automated "Idaho Child Support Enforcement System" (ICSES).

We reviewed the four quarterly reports submitted during FY 01 and found unexplained adjustments in each quarter. In each case, the adjustment was to resolve a variance between the balance shown as "undistributed collections" and the calculation of this balance as supported by the details. The variance each quarter was:

Quarter Ending	Reported Balance	Calculated Balance	Difference
September 2000	$129,504.19	$56,241.96	$73,232.23
December 2000	127,833.39	102,956.90	24,876.49
March 2001	217,504.71	185,450.82	32,053.89
June 2001	197,383.04	115,241.45	82,141.59

The "calculated balance" simply takes the balance not distributed at the end of the prior quarter, adds total collections, and subtracts amounts distributed.

The Department was unable to isolate the reasons for these differences

or what effect they may have had on other reported amounts. Although the differences are likely formula errors in the ICSES program, the potential exists that other errors in detailed transactions occurred. This adversely affects the overall integrity and reliability of the financial data.

Recommendation #3

We recommend that the Department identify and correct the errors in the ICSES data and related information in the federal financial reports.

Corrective Action Plan

We have identified and corrected two major elements of the difference on the Undistributed Collections line on the OC34.

Non Sufficient Funds (NSF) checks were not accounted for in ICSES prior to 9/1/01. Non Sufficient Funds are now processed through ICSES.

Federal Tax Offset (FTO) adjustments previously decreased collection but not distribution. The FTO Six Month Holding was implemented in ICSES on 9/1/01 and corrected this problem.

Variances are still being created because NSFs decrease collections on the OC34 but not distributions. This is impacting the undistributed line of the OC34 . We are waiting on a response from OCSE to determine the appropriate method to account for these collections and distributions. Once a reply is received, ICSES will be programmed accordingly.

ICSES and FISCAL staff are working closely together to isolate all other collection types needed to accurately calculate undistributed collections. Once the requirements have been determined, the ICSES OC34 module will be programmed accordingly. This will eliminate the remaining variances and achieve a total reconciliation.

Finding #4

Federal funds were claimed in error for the State share of Medicare premiums.

CFDA Title and #:	Medicaid – 93.778
Federal Award #:	05-0005ID5028
Program Year:	October 1, 1999 to January 30, 2001
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	C – Cash Management
Questioned Costs:	$13,000 Federal Share

Various types of costs are allowable for federal participation under the Medicaid program. One of these is premiums paid to the federal Medicare program, which is known as the "premium buy-in" program.

Federal participation in these premium costs is based on client eligibility and involvement in other assistance programs. If a client is ineligible, the Department can choose to enroll him or her in this program if it is cost-effective to do so. However, premiums for these clients are not eligible for federal participation. These costs are known as "state-only premium buy-ins."

The documentation for monthly premium payments clearly shows the

amounts that are either eligible for federal funding or are "state-only." However, the state-only amounts have routinely been included in the claims for federal participation in error. This error has occurred each month for at least the past three years.

During FY 01, the Department paid more than $2 million in state-only premiums, resulting in about $125,000 in federal funds claimed each month in error. Although these funds were returned to the grantor during the quarterly reporting process, they were in excess of current needs for up to 90 days each quarter.

This violates the spirit of the Cash Management Improvement Act (CMIA), which requires states to minimize the time between the transfer and disbursement of federal funds. As a result, an interest liability has accrued to the federal grantor, which we estimate to be about $13,000 for FY 01. The State's liability for prior years was not evaluated but would likely be a similar amount each year.

Recommendation #4

We recommend that the Department exclude state-only premiums from the federal draw process and resolve the interest liability issue with the federal grantor for the current and prior fiscal years.

Corrective Action Plan

State only premiums have been excluded from federal draws effective December 28, 2001. We will coordinate with the Division of Financial Management to recognize an interest liability of $13,000 as part of the annual state CMIA interest settlement for 2002.

Finding #5

Errors exist in determining the cost-effectiveness of some Medicaid services.

CFDA Title and #:	Medicaid – 93.778
Federal Award #:	05-0005ID5028
Program Year:	October 1, 1999 to January 30, 2001
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	A – Activities Allowed/Unallowed
Questioned Costs:	Not Determinable

Federal regulations allow the Department to develop cost-effective programs to meet client needs. One of these programs is known as "waivered services." This program allows the Department to waive certain eligibility requirements so clients can receive services that are less expensive than institutional care.

Most waivered services are part of the Home and Community Based Services (HCBS) program. We evaluated the "aged and disabled" waiver program, which allows the Department to fund personal care services, shelter care, and related living costs if it is more cost-effective than comparable services at a nursing facility.

The decision to enroll clients in a waivered service program is based on a cost-effectiveness calculation. This calculation compares the costs Medicaid would pay for waivered services to those included in the "content of care" at a nursing facility or other traditional service provider. This calculation also determines the daily rate paid to the waivered service provider.

Our review of HCBS waivered services was limited to six clients from three regions. In each case, we identified errors and omissions in the calculation used to support the cost-effectiveness and rates paid to vendors. We categorized these errors and omissions as follows:

1. Significant costs were omitted from the comparison. Costs for transportation, day treatment, and other services relating to a nursing facility's "content of care" were omitted from the comparison. If these costs were included, waivered services would have been denied in at least one instance.

2. Client resources were not fully considered. Client funds used to pay for rent, utilities, and food were excluded from the comparison, even though these resources are available to offset the cost of nursing care services.

3. Adjustments were not consistently made. One calculation we reviewed included an adjustment for periods when the client was out of the residential facility. However, this adjustment was not made for other clients at this facility who had the same schedule.

4. Various clerical and mathematical errors existed. Most clerical errors had a minimal effect on the cost-effectiveness or daily rate determination. However, the potential exists for significant errors to occur and alter the conclusion of cost effectiveness or the daily rate paid to the provider.

Although our sample size was small, we believe the results indicate a potential for clients to receive waivered services that are not cost-effective for their needs.

Most errors occurred due to the complexity and number of variables considered in these calculations. Although efforts have been taken to develop an automated worksheet, additional training and review is needed to reduce errors, omissions, and the inappropriate placement of clients in waivered service programs.

Recommendation #5

We recommend that the Department review all clients under the HCBS aged and disabled waiver program to ensure that cost-effectiveness and daily rates were properly determined.

We also recommend that staff receive additional training regarding costs, adjustments, and other elements necessary to properly calculate the cost-effectiveness and daily rates for waivered services.

Corrective Action Plan

Medicaid regulations at 42 CFR 441.302(c)(2) require the Department to conduct an annual review of all HCBS waiver clients. We will perform a cost-effectiveness determination as a part of this review process. Based on the current rate of reviews, we will have verified cost effectiveness on all waiver clients by June 1, 2003.

The Division of Medicaid has undertaken three major initiatives to improve its assessment process for establishing waiver services

eligibility.

Over the past six months, the Division has been working with the Department's Information and Technology Services Division to automate the Uniform Assessment Instrument (UAI) to 1) incorporate an electronic spreadsheet to calculate cost effectiveness and 2) combine these tools on a common server. Each section of the UAI has been reviewed in order to establish common definitions and requirements. The automation of the UAI will promote improved coordination and standardization of assessments. Additionally, with all assessments in a common data base, management ability to monitor and audit all waiver client determinations will improve. Target implementation date is August 2002.

The Division is taking this opportunity to re-structure training on how to complete the UAI. The training plan incorporates an initial central office training that provides staff with a basic understanding and application of the UAI complimented by a field hands-on training. This training includes interviewing and documentation instruction. On-going training, conducted in the regions, will continue through a mentoring process. In preparation for statewide training, key central policy staff met with regional staff to identify common definitions and assessment criteria.

With the Division's development of a quality assurance program, a self-assessment tool is being introduced that will enable central and regional management to evaluate compliance with federal and state requirements. As part of this self-assessment process, regional Medicaid management will be required to conduct a cost-effectiveness determination as part of the annual HCBS waiver review.

Finding #6

Child support services are not provided within required time frames.

CFDA Title and #:	Child Support Enforcement – 93.563
Federal Award #:	G0004ID4004
Program Year:	October 1, 1999 to September 30, 2000
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	N - Special Tests
Questioned Costs:	Not determinable

Federal regulations require the Department to perform some services within a specific number of days. For example, court orders for child support must be established within 90 calendar days of locating the non-custodial parent.

Tests to determine that services are provided within the required time frames showed error rates greater than 10% in the cases selected. For the requirement to request federal parent locator services, the error rate was greater than 80% due to automated processes that allowed delays to occur and go undetected.

The specific requirements and results of our tests are:

1. Establishment of Paternity and Support Obligations

A. Federal regulation (45 CFR 303.5) requires the Department to take steps to establish paternity for cases needing this type of service. When an alleged father is located, the process for establishing paternity should begin. We selected 20 cases needing paternity services and identified three (15%) where efforts to establish paternity did not begin when the non-custodial parent was located.

B. Federal regulation (45 CFR 303.4 (d)) requires the Department to establish an order for support or complete "service of process" (issue a summons) within 90 calendar days of locating the non-custodial parent. These efforts are required, regardless of whether paternity has been established. We tested 32 cases needing paternity services and found eight (25%) did not receive the required efforts within 90 days. In most instances, the referral for "service of process" was completed more than 30 days late, but the reason for the delay was not documented.

C. Federal regulation (45 CFR 302.33 (3)) requires the Department to request Federal Parent Locator Services (FPLS) within 75 calendar days of determining that location services are necessary. We tested seven cases needing location services and determined that six (86%) were not referred for FPLS within 75 days as required. The automated case management system notifies staff when a referral is due. However, in the cases tested the date used by the system to notify staff was later than the date services were actually needed. As such, the notification from the system was routinely beyond the 75 days allowed.

2. Provision of Child Support Services for Interstate Cases

A. Federal regulation (45 CFR 303.7) requires the Department to respond to interstate case requests within 10 working days. The Department must establish the case within the central registry, refer it to the proper region, and notify the requesting state of these actions. We tested 60 interstate case requests received during January 2002 and identified 17 (28%) where the Department did not respond within the required 10 days. Most delays in responding were the result of changes in staffing and assignment of duties.

B. Federal regulation (45 CFR 303.7 (b) (2)) requires the Department to refer cases to another state within 20 calendar days of determining that the non-custodial parent is in that state. The referral of cases to other states is also not completed within the required time frame. We tested eleven cases needing interstate referral and identified seven (64%) that were not referred within 20 days as required. In four instances, the cases were not referred for more than 120 days. Although the cause for most delays was not apparent, we did note that one referral was delayed due to incomplete data

received from the applicant.

As a result, services to clients are not provided in a prompt manner which could adversely affect efforts to collect support for custodial parents. In addition, sanctions may be imposed by the federal grantor which could reduce federal funding or other incentive awards and payments received by the Department.

Recommendation #6

We recommend that the Department deliver services within the required time frames by identifying the mechanisms used to track due dates for services, and to monitor compliance to these requirements. Adjustments are needed to automated processes used to identify when services are due. Additional training and a raised awareness of the time frames for services should also be considered.

Corrective Action Plan

The Department is evaluating the factors involved in tracking due dates for services and monitoring compliance, outlining the steps needed to assure service delivery within federal timeframes and addressing training issues.

We currently have a pilot project which is putting Deputy Attorneys General in rotation with the contract attorneys on paternity and establishment referrals. This project gives the Department more control over the CFR timeframe compliance. The project goes statewide effective approx. 7/01/02. We are reviewing current policy to be sure it complies with federal timeframes. We have identified and are in the process of correcting the information request timeframes to the Federal Parent Locator System (FPLS). We plan to have compliance processes completed by September 30, 2002.

Finding #7

Additional efforts are needed by the Child Support program to pursue and share health insurance data.

CFDA Title and #:	Child Support Enforcement – 93.563
Federal Award #:	G0004ID4004
Program Year:	October 1, 1999 to September 30, 2000
Federal Agency:	Department of Health and Human Services
Compliance Criteria:	N - Special Tests
Questioned Costs:	Not determinable

Federal regulation (45 CFR 303.31 (7)) requires the Department to include health insurance in all court orders for support and take steps to enforce this support. Enforcement efforts are taken only if insurance coverage is available to the non-custodial parent at a reasonable cost. "Reasonable cost" is defined by the Department as insurance that is available through a parent's employer.

The Department is also required by federal regulation (45 CFR3 03.31 (b) (6)) to inform the Medicaid program of any new or modified health insurance information when it becomes available.

We tested 29 cases that had health insurance included in the court order and identified three (10%) where enforcement efforts were not taken or properly documented. Our tests included confirming the non-custodial parent's employment status during the past 12 months and

whether health insurance data was obtained or actively pursued. In the three cases with errors, the custodial parents were employed and may have had insurance available through their employers.

We also noted that no systematic process exists for the Child Support and Medicaid programs to share medical insurance data. In one of the selected cases, the Medicaid program had valid insurance data which was not known by the Child Support program. The potential also exists for the Medicaid program to incur costs in obtaining insurance data already known by the Child Support program. Coordinating health insurance data between these programs could improve compliance, limit unnecessary efforts, and reduce program costs.

As a result, efforts to pursue and share health insurance data are incomplete and may limit the program's success in obtaining health insurance coverage for children. In addition, sanctions may be imposed by the federal grantor which could reduce federal funding or other incentive awards and payments received by the Department.

Recommendation #7

We recommend that the Department enforce medical support requirements and coordinate efforts of the Child Support and Medicaid programs in obtaining health insurance data. Enforcement should include systematic efforts to contact non-custodial parents and their employers and document whether health insurance is available.

Corrective Action Plan

Current policy sets “reasonable cost” of health insurance as having insurance available through one’s employer. The Department is aware of a shortcoming in this policy, as it provides no consistent formula or basis with which to arrive at “reasonable cost”. We are currently addressing the reasonable cost issues, as is the federal Office of Child Support Enforcement (OCSE). We will define reasonable cost and determine what statutory changes will need to be made so they may be addressed in the next legislative session. In the meantime, we will be monitoring the consistent application of current policy.

The Department is currently in the process of working with OCSE to begin utilizing the National Medical Support Notice. This notice will give the Department the ability to get more information regarding the available health insurance for noncustodial parents. The Department is in the process of determining what statutes and departmental changes must be made to be in compliance with this federal required notice by Spring 2003. The work group formed to work with OCSE will also determine training needs statewide in order to implement the National Medical Support Notice..

The Bureau of Child Support currently interfaces health insurance information with the Division of Medicaid.

OTHER ISSUES – In addition to the findings and recommendations, we discussed other less important issues which, if changed, would improve internal control, ensure compliance, or improve efficiency.

This letter is intended solely for the information and use of the Department of Health and Welfare and

the Idaho Legislature, and is not intended to be, and should not be, used by anyone other than these specified parties.

We appreciate the cooperation and assistance given to us by the Department and its staff.

QUESTIONS CONCERNING THIS DOCUMENT SHOULD BE DIRECTED TO:
Ray Ineck, CGFM, Supervisor, Legislative Audits
Don Berg, CGFM, Managing Auditor